Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: VISTA MEDICAL CENTER HOSPITAL 4301 VISTA ROAD PASADENA TX 77503	MFDR Tracking #: M4-04-3757-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: SIERRA INSURANCE CO OF TEXAS Box #: 13	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum of 70% of billed charges. This is supported by a managed care contract with 'Focus"…This managed care contract supports Vista Medical Center Hospital's argument that the usual and customary charges are fair and reasonable and **at the very minimum**, 70% of the usual and customary charges is fair and reasonable…the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers medical services." "…amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, TWCC stated specifically that managed care contracts are fulfill the requirements of Texas Labor Code Section 413.011 as they are 'relevant to what fair and reasonable reimbursement is,' they are relevant to achieving cost control,' they are relevant to ensuring access to quality care,' and they are 'highly reliable.' See 22 TexReg 6272. Finally, managed care contracts were determined by the TWCC to be the best indication of a market price voluntarily negotiated for medical services."

Amount in Dispute: $32,547.27

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent paid the Requestor $1,118.00 for the services described above. This is the surgical per diem rate for the State of Texas." "Respondent used the denial code 'E' to note a compensable issue in regards to this claimant. This code was mistakenly used as there is no compensability issue with regards to this injury. The Requestor was properly paid for their services."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/11/2003 through 4/12/2003	E, F, M, O	Inpatient Surgery	$32,547.27	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on November 19, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 25, 2003 to send additional documentation relevant to

the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code(s):
   - E-Entitlement to benefits.
   - F-Fee guideline MAR reduction.
   - M-No MAR.
   - O-Denial after reconsideration.
2. The respondent states in the position summary that "Respondent used the denial code 'E' to note a compensable issue in regards to this claimant. This code was mistakenly used as there is no compensability issue with regards to this injury." Since a compensability issue does not exist in this dispute, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
3. Division rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." A review of the submitted medical bill and itemized statement, indicate that the requestor billed for 34 hours of observation in addition to other services related to this admission. The Division concludes that the claimant's length of stay exceeded 23 hours; therefore, this admission meets the definition of inpatient services per Division rule at 28 TAC §134.401(b)(1)(B).
4. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401.
5. Division rule at 28 TAC §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118.00."
6. Based upon the submitted medical bill, the hospital inpatient stay was from 4/11/2003 through 4/12/2003; therefore, the length of stay equals one day.
7. Per Division rule at 28 TAC §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 1 day X $1118.00 surgical per diem rate/day = $1,118.00. The insurance carrier paid $1,118.00. The difference between amount due and paid is $0.00; this amount is recommended for reimbursement.
8. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." Review of the Table of Disputed Services finds that the requestor listed the disputed date of service as "04/``/03 -04/". The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(2)(C).
9. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care records, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(C), §133.307(g)(3)(B). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		4/20/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		4/20/2011
Authorized Signature	Health Care Business Management Director	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.